COVENANT

AUTHORIZATION FOR MEDICATION ADMINISTRATION

STUDENT'S FIRST NAME | LAST NAME | GRADE LEVEL | DATE OF BIRTH

PARENT/GUARDIAN'S PERMISSION FOR SCHOOL TO ADMINISTER MEDICATION

MEDICATION | DOSAGE | FREQUENCY | DURATION

START DATE | DRUG ALLERGIES | SPECIAL INSTRUCTIONS

REASON FOR MEDICATION | MEDICATIONS TAKEN AT HOME

Parent/Guardian- please sign at the bottom of this form.

PHYSICIAN'S ORDER FOR SCHOOL TO ADMINISTER MEDICATION

MEDICATION | DOSAGE | FREQUENCY | DURATION

START DATE | DRUG ALLERGIES | SPECIAL INSTRUCTIONS

MEDICAL DIAGNOSIS | MEDICATIONS TAKEN AT HOME

PHYSICIAN'S SIGNATURE | PHYSICIAN'S PRINTED NAME | DATE | PHONE NUMBER

GENERAL GUIDELINES FOR PARENT/GUARDIAN

1. A physician's signature is required for: prescription medication given more than 10 days, prescription medication changes, non-prescription medication given more than 4 times per month or if the requested dosage of a non-prescription medication is more than what is recommended on the label. Prescriptions are valid for the current school year.
2. A parent's signature is required for the administration of any medication. Containers must be labeled with student's name.
3. Prescription medications must be in their original container. The pharmacy label must have the name of the student, name and phone number of the ordering physician, name of the medication, administration directions and a valid date.
4. Changes to or discontinuance of a medication must be made in writing by parent/guardian or by the prescribing physician.
5. Medications must be delivered and picked up by parent/guardian. Medication left at end of school year will be destroyed.
6. For non-prescription meds, the nurse will not be able to exceed the labeled dosage for the age/wt. except with a physician's order.

I authorize the school nurse or other qualified staff members to administer and document medication to the above listed student. This student has not previously suffered from side effects of this medication. The school nurse may contact the prescribing physician, if needed. I am aware that medication information may be shared with other school personnel who are in contact with the student. I know that I am responsible for dropping off and picking up the above listed medication and that medication remaining at the end of this school year will be disposed of in a proper manner. I understand that the law states there shall be no liabilty for civil damages resulting from medication administration. I have read the above guidelines.

PARENT/GUARDIAN SIGNATURE | PARENT/GUARDIAN PRINTED NAME | DATE